From:	Margie_Baricevich@ssmhc.com
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Comments on Draft Redesigned Form 990 and Schedules
Date:	Friday, September 14, 2007 1:26:52 PM
Attachments:	990 comments_20070914131513.pdf

Any questions please contact Kris Zimmer or Steve Hoven at 314-994-7800

Thank You
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SSM HEALTH · CARE℠

September 13, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

Sponsored by the Franciscan Sisters of Mary and based in St. Louis, Missouri, SSM Health Care is one of the largest Catholic health care systems in the country. The system owns, manages and is affiliated with 20 hospitals and two nursing homes in four states: Missouri, Illinois, Oklahoma, and Wisconsin.

More than 5,000 affiliated physicians and 24,000 employees work together to provide a wide range of services including emergency care, rehabilitation, pediatrics, home care, hospice, residential and skilled nursing care.

On behalf of our health care providers and employees, SSM Health Care appreciates the opportunity to comment of the draft redesigned Form 990 and select supplemental schedules.

Core Form

We have many concerns about the new core form and supplemental schedules including the tight turnaround time for implementation of procedures to collect and report the vast amount of detail required for the new form and schedules. Many of our hospitals will need to complete as many as 14 schedules, and most will have to fill out at least 8-10. This is an enormous, expensive and time-consuming undertaking for tax-exempt hospitals. We think it is critical that exempt organizations be given an opportunity to review the revised set of forms, schedules and instructions in their entirety, with another 90-day review period following the re-draft. The IRS should release the second draft with instructions in 2008, and provide another 90-day review period, with a final form release by December 31, 2008.

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Malcolm Baldrige National Quality Award 2002 Award Recipient

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

- Part II (Compensation and Other Financial Arrangements with Officers, Directors, Trustees, Key Employees, Highly Compensated Employees, and Independent Contractors), Section A requires information on key employees, which term is defined in part based on the disqualified person concept from the Section 4958 intermediate sanction regulations to include a "person who manages a discrete segment or activity of the organization that represents a substantial part of the activities, assets, income or expenses of the organization, as compared to the organization as a whole." Consideration should be given to defining "substantial part" or including examples in the instructions or glossary to help large organizations determine employees who would fall under the broadened definition. Hospitals could potentially have a large number of "key employees" if this definition is not clear.
- Part II, Section A requires an organization to list the city and state of residence of each listed individual or organization. For hospitals and heath care organizations in rural areas, providing this information could be tantamount to providing an individual's home address.
- Part II, Section A requires an organization to include reportable compensation from "related organizations" for purposes of reporting the compensation of former (within the last five years) directors, trustees, officers and key employees or highest compensated employees. This requirement adds a substantial burden to a large organization to track all former directors, trustees, officers, key employees and highest compensated employees over a six-year period. We believe combining this requirement with a need to survey all related organizations to determine if any such organization paid compensation to any individual in this group requires efforts beyond the value the information would provide. We believe that information on directors, trustees, officers, key employees or highest compensated employees should look to current year only.
- Part II, Section B, Lines 5a-f requires an organization to report the family and business relationships of officers, directors, trustees or key employees during a five-year look-back period. Hospital and health care organizations often have boards of directors with as many as 30 members, and hundreds of contracts. The collection and maintenance of documentation required to respond to these questions will create excessive new burdens for organizations, especially for organizations with large boards of directors.

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Moreover, the instructions should clarify the duties of organizations to collect such information going forward.

- Part II, Section B, Line 9 requires an organization to report whether any persons listed in Part A receive compensation from any source other than the filing organization or a related organization for services rendered to the organization. In its current form, this question requires organizations to have or acquire access to information that is invasive of the privacy of such individuals, and which they may not otherwise have. This question should be clarified to address the extent to which an organization is required to seek information regarding such compensation arrangements. Also, if a listed person owns a business that does work for the hospital and is a salaried employee of that business, what amount, if any, gets reported?
- Part III (Statements Regarding Governance, Management, and Financial Reporting), Line 2 requires an organization to report any significant changes to its organizing or governing documents. The IRS should clarify that this question would only cover changes to articles of incorporation and bylaws and not other policies of the organization.
- Part III, Line 3b requires an organization to report the number of "transactions" the organization reviewed under its conflict of interest policy. The instructions or glossary should be revised to include a definition for "transactions." Responding with a zero or a very high number of transactions could create a misleading, negative connotation because the meaning of any numerical response will depend on the organization and its policy. We believe meaningful information would be provided if the question were revised to ask whether the organization engaged in any transactions that were subject to the policy but were not reviewed under the policy.
- Part III, Line 10 asks whether an organization's governing body reviewed the Form 990 before it was filed. If this question signals an expected standard, it is overly burdensome, particularly for large hospital systems, which may have dozens of hospitals and related entities for which returns are being filed. Further, the draft form does not provide a definition of "review," which should be added to the instructions or glossary. It is unclear whether the question is whether the Form 990 was provided to its governing body or whether each member, or a subset, of its governing body has certified that it has reviewed the form. In clarifying what is meant by "review," the IRS also should consider that boards of directors of public companies are not required to review or certify tax filings under the Sarbanes-Oxley Act.

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- Part VII, Lines 11 and 12 require an organization to report whether it has a written policy or procedure for reviewing the organization's investments and safeguarding its exempt status with respect to transactions and arrangements with related organizations. To the extent the IRS intends to develop sample written policies, we suggest that the IRS solicit input from members of the tax-exempt sector with respect to the content and form of such written policies.

Schedule D (Supplemental Financial Statements)

- Parts I and III: Passive investments should be excluded from this schedule and the listing of securities individually is extremely burdensome for large organizations. It is not clear how an ownership interest in the commingled funds of related organizations should be disclosed.
- Part VII (Other Liabilities) requires organizations to describe and list the book value of any other liabilities, including federal income tax liabilities, not reportable in the defined categories on Part VI (Balance Sheet) of the core form. Part VII also requires organizations to provide the text of the footnote to the organization's financial statements that report the organization's liability for uncertain tax positions under FIN 48. Disclosing the text of footnotes relating to uncertain tax positions in isolation could be misleading. Organizations should be given the opportunity to explain such footnotes or to attach their entire financial statement.

Schedule H (Hospitals)

The hospital community has demonstrated in many ways its commitment to transparency. However, even under ideal conditions, the burden of reconfiguring financial and data recordkeeping systems to capture by January 1, 2008 the substantial amount of information required just for Schedule H is a daunting task. It is made virtually impossible without the necessary instructions, definitions and worksheets that the IRS does not expect to finalize until the following June. Even if the IRS completes the revised form and instructions before June 2008, it is impossible for hospitals to predict what will need to be changed to permit data collection by January 1, 2008. Given the number of concerns and questions about Schedule H, we urge the IRS to provide a second draft in 2008, followed by a review period, with a goal of finalizing the schedule and instructions by December 31, 2008. That would give hospitals all of 2009 to revise their financial and data record-keeping systems so that they accurately capture the new information that would be reported for tax year 2010.

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

Medicare Underpayments and Bad Debt – Community Benefit

The IRS should incorporate the full value of the community benefit that hospitals provide by counting Medicare underpayments as quantifiable community benefit and modifying the chart, instructions and worksheets accordingly. That is because:

- Providing care for the elderly and serving Medicare patients is an essential part of the community benefit standard.
- Medicare, like Medicaid, does not pay the full cost of care. The Medicare Payment Advisory Commission (MedPAC) in its March 2007 report to Congress cautioned that underpayment will get even worse, with margins reaching a 10-year low at *negative* 5.4 percent.
- Many Medicare beneficiaries, like their Medicaid counterparts, are poor. According to MedPAC's June 2007 Data Book on Healthcare Spending and the Medicare Program, approximately 49 percent of the Medicare population in 2004 had income at or below 200 percent of the federal poverty level. Many of those Medicare beneficiaries are also eligible for Medicaid -- so-called 'dual eligibles." There is every compelling public policy reason to treat Medicare and Medicaid underpayments alike. Medicare underpayment must be shouldered by the hospital in order to continue treating the community's elderly and poor. These underpayments represent a real cost of serving the community and should count as a quantifiable community benefit. Patient bad debt is a community benefit. Like Medicare underpayment, there also are compelling reasons that patient bad debt should be counted as quantifiable community benefit.
- A significant majority of bad debt is attributable to low-income patients, who, for many reasons, decline requests to complete the forms required to establish eligibility for hospitals' charity care or financial assistance programs. A 2006 Congressional Budget Office (CBO) report, *Nonprofit Hospitals and the Provision of Community Benefits,* cited two studies indicating that "the great majority of bad debt was attributable to patients with incomes below 200% of the federal poverty line."
- The CBO concluded that its findings "support the validity of the use of uncompensated care [bad debt and charity care] as a measure of community benefits". The experience of hospitals around the nation reinforces that the findings are generalizable across the industry. Despite hospitals' best efforts, patient bad debt is a fact of life. The IRS should not ignore it or attribute it to a lack of industry on the part of the tax-exempt

hospital community. It is, rather, part of the evolving burden hospitals must shoulder in helping patients who, for many reasons, decline to take advantage of available financial assistance. It is a real cost of serving the community and the IRS should recognize any reasonable method to count patient bad debt as a quantifiable community benefit.

Eliminate Questions Unrelated to Community Benefit

The proposed chart on draft Schedule H, Part II relating to billing should be eliminated for many reasons. First, because the information sought in the chart has no relationship to the community benefit standard, it does not contribute to the IRS' goal of promoting compliance. Second, the data requested could be competitively sensitive. In markets across the country that are characterized by a shrinking number of health insurance plans, providing information about discounts could reveal confidential information on the rates negotiated with insurers.

Other Recommended Improvements to the Form:

- For a number of questions, including those pertaining to assessing community health needs, community benefit reports and charity care policies, the amount of space provided may not be sufficient to fully describe the hospital's activities, programs or policies,. We recommend that the IRS permit (not require) the insertion of live links to such information on a hospital Web site, or allow attachments. The IRS already allows attachments to draft Form 990 and should do so here or permit live links.
- Questions on management companies and joint ventures should be combined on one form or eliminated. In the draft form, hospitals are required to provide information about joint ventures in three different forms: Form 990, Schedule H and Schedule R. This redundancy does nothing to enhance transparency or minimize burden. As a result, these questions should be eliminated from Schedule H.
- If these questions are significant to the IRS, then the entire tax-exempt sector should be required to respond to them. Questions on potential private inurement or benefit arising from ventures, for example, pertain to all exempt organizations, not just hospitals. It is unfair to hospitals, and ultimately to those who use the information provided, to limit those questions to Schedule H.

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- Who must file should be clarified. As drafted, all organizations that respond "yes" to the question "Did the organization operate, or maintain a facility to provide hospital or medical care?" must complete Schedule H. This question is too broad and will sweep up facilities that are not hospitals. A definition of "hospital" should be added as follows:

  "A hospital is a health care organization that has a governing body, an organized medical staff and professional staff, and inpatient facilities and provides medical, nursing, and related services for ill and injured patients 24 hours per day, seven days per week. A hospital is a facility (and all of its components) that is licensed in its state as one of the following:

  a. hospital
  b. chronic disease hospital or hospital for treating certain disease categories
  c. rehabilitation hospital
  d. acute long term care hospital
  e. children's hospital
  f. psychiatric hospital
  g. research hospital

  "A hospital does not include:

  a. a nursing facility (including a skilled nursing facility, convalescent home, or home for the aged)
  b. free standing outpatient clinic
  c. community mental health or drug treatment/rehabilitation center
  d. physicians' offices
  e, facility for mentally retarded/developmentally disabled
  f. facility for treating alcohol and drug abuse
  g. hospital wing of a school, prison or convent
  h. faculty practice plan"

- The question on charity care policies should be reformulated. The question now labeled 13b on charity care policies should be revised to include in the description whether the organization (a) bases eligibility for free or discounted care on federal poverty guidelines, income or asset levels, (b) applies such policy to all of its facilities and allows its facilities to adapt its policy to particular community or individual needs, and (c) budgets annually for charity care.

Hospitals are often faced with situations where patients in need don't neatly fit into a predetermined category, and hospitals need to deviate from their policies to provide assistance. The question should anticipate that hospital policies will need to be flexible enough to accommodate those situations.

- As drafted, Schedule H must be completed in the aggregate for all facilities/hospitals under a single EIN. Part IV Facility Information asks for each "facility" to be listed. Filers with multiple hospitals under a single EIN should have the option to complete Schedule H on either an aggregate basis or by completing it for each hospital included in the EIN.
- Line 12a should be revised to ask whether the organization *or a related organization* prepares an annual community benefit report. This reflects the fact that, within a health system, an affiliated foundation of a hospital or the parent holding company may actually prepare a system-wide or hospital-specific community benefit report on behalf of the hospital.
- The facility chart requires that the programs be described for each facility. This information could amount to multiple pages for many hospitals. The chart should be Internal Revenue Service streamlined to ask only for the name and address of the facility in column A and for the "type" of facility in column B.

Schedule J (Supplemental Compensation Information)

- Schedule J requires an organization to report supplemental compensation information with respect to listed persons from Part II of the core form. There still seems to be confusion about who gets reported on Schedule J, so the instructions should further clarify the individuals for whom such information must be reported.
- Line 1, column (D) requires an organization to report the amount of non-taxable fringe benefits provided to the listed persons in column (A). The instructions seem to even require reporting of de minimis fringe benefits, which by definition under the Internal Revenue Code, are "so small as to make accounting for it unreasonable or administratively impracticable." The instructions should follow the current Form 990, which allows de minimis fringe benefits to be excluded. The instructions or the compensation matrix also should include examples of nontaxable fringe benefits that physicians would typically be issued as part of providing services at a hospital (e.g., pagers, cell phones and other similar items), or this requirement should be eliminated.

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

- Line 1, Column (E) requires an organization to report the amount of all expense reimbursements, and allowances provided for expenses, that are not included on a recipient's W-2. It is completely misleading to report such amounts on Schedule J, which is intended to disclose compensation amounts. Expense reimbursements under accountable plans that do not result in income to the recipient should not have to be reported on Schedule J.

Schedule K (Supplemental Information on Tax Exempt Bonds)

We are particularly concerned about Schedule K because of the burden associated with this schedule are akin to a full-scale audit, costing, potentially, millions of dollars. Schedule K requires an organization to report supplemental information for each outstanding bond issue with an aggregate principal amount in excess of $100,000 on the last day of the taxable year. Due to the scope of information required for reportable tax exempt bonds, the IRS should delay implementation of Schedule K (along with all of the Form 990) until 2010 so that organizations will have sufficient time to complete the analyses required for reporting the new information on the schedule. Also, since the schedule asks for information regarding all bonds outstanding on the last day of the taxable year, no matter how long ago the bonds were issued, organizations may not have all of the requested information because there was no notice at the time the bonds were issued that the organization would be required to report such information to the IRS. Accordingly, the IRS should provide a "grandfather" provision under which information is required to be reported only for bonds issued after the date that the redesigned Form 990 was made public. Also, in light of the IRS' recently announced post-issuance compliance check program, the IRS should consider delaying finalization of this Schedule until the IRS has analyzed the responses to the questionnaires being sent out as part of the program.

- Part I requires extensive information for each outstanding tax-exempt bond issue with a principal amount greater than $100,000 on the last day of the tax year. This section is enormously burdensome and needs to be streamlined. First, the IRS should recognize that much of the information requested here is already available through Form 8038, Information Return for Tax Exempt Private Activity Bond Issues, which is filed when the bonds are issued. Requests for information already reported should be eliminated. Part I, columns F and G, in particular, represent a particular burden for hospitals. For example, for bonds with large principal amounts that funded multiple projects, including buildings and equipment, requiring information on the date that each project and financed piece of equipment was placed

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

into service difficult and burdensome to provide. Similarly, data on items financed on outstanding bonds issued years earlier will require many hours of research into the property records.

- Part II requires the provision of information on bond proceeds. If funds are used to refinance an issue, it should not be necessary to report how the proceeds of the prior issue were spent. Alternatively, the instructions should reduce the burden associated with reporting this information by, for example, limiting how far an organization must go back when a bond is used to refund a prior issue. In addition, the current IRS regulations permit an organization that funds projects with a mixture of equity and bond proceeds to wait 18 months after facilities are placed into service to allocate the sources of those funds to particular costs. That means, at the time an organization may be required to file this schedule, there may not be a final allocation. The instructions for the form should reconcile this inconsistency in favor of delayed reporting.
- Part III requires an organization to report information about private use of tax-exempt bonds. The instructions should clarify that aggregate reporting for private business use is contemplated and the IRS should consider permitting organizations to report private business use as not exceeding a stated de minimis percentage. And, Part III could be streamlined if it allowed organizations to limit the reporting of contracts to those that do not meet the "safe harbors" described in Revenue Procedures 97-13 or 97-14. Question 4 should be re-written, as it does not take into consideration that a hospital may be meeting such "safe harbor" requirements, which would make the percentage computation unnecessary. Also, question 5a, requesting information about all other "use" by other than a 501(c)(3) organization or state or local government is overly broad, as it would presumably include use that is not treated as private use, such as incidental use or use on the same basis as the general public. Additionally, questions 4 and 5 could result in misleading answers, as they fail to anticipate that these percentages may change from year to year and that the proper measure of usage would be the entire term of the bond.
- Part IV requires an organization to report information about the compensation of third parties who provide services related to bond issuances and whether such parties were selected using a "formal selection process." The instructions should clarify what is meant by a "formal selection process" and should permit organizations to rely on selections that involved advice of bond counsel and/or a qualified underwriter with a

reasonable review of qualifications. In addition, a threshold amount for reportable transactions should be added.

Schedule N (Liquidation, Termination, dissolution or Significant Disposition of Assets)

- Clarification is needed as to whether transfers to a wholly owned limited liability company that is disregarded as separate from the tax-exempt filing organization need to be reported.
- Clarification is needed as to whether transfers for "full and adequate consideration" that are excluded from the definition of "substantial contraction" still need to be reported as a disposition of net assets.

Schedule R (Related Organizations)

The following comments relate to Part V – Transactions with Related Organizations.

- For multi-hospital systems such as SSM Health Care, Schedule R is extremely burdensome. At a minimum, the definition of "related" needs further review and consideration, as there are many definitions of the term that might have been used.
- Part V requires an organization to report whether it engaged in certain transactions or transfers with related organizations, including related 501(c)(3) organizations. The instructions carve out transactions between 501(c)(3) organizations where the only transactions between the organizations were gifts or grants. This instruction should be revised to allow transfers that are gifts and grants to be excluded, even where the organizations have other transactions such as leasing or services arrangements.
- The definition of "transfer" in the instructions should be revised as follows: A transfer includes any conveyance of funds or property, whether or not for consideration, *except for gifts or grants between related 501(c)(3) organizations*.
- The compliance burden from this section is expected to be significant. SSM Health Care has numerous arrangements between its entities involving the performance of certain centralized services, leasing or sharing of facilities, equipment or employees, cost reimbursement etc. By way of example, a typical 501(c)(3) health system could have hundreds of transactions to report under Part V. We understand that certain questions on this schedule

are in response to Section 1205 of the Pension Protection Act (PPA). However, Schedule R exceeds what is required under the PPA. The information on transactions between related 501(c)(3) organizations should be limited to transfers that could result in UBIT under the controlled entity rule of Section 512(b)(13). Other transactions between related 501(c)(3) organizations do not raise compliance, exemption, tax or other concerns and should not need to be reported.

- The instructions for column (C) require the amount involved in each transaction to be reported, which is defined as the fair market value of the services, cash and other assets provided by the organization or the fair market value received, whichever is higher. This instruction seems to require even related 501(c)(3) organizations that have cost reimbursement arrangements to determine the fair market value for these arrangements, which creates a significant valuation burden for arrangements that should not even need to be reported.

We appreciate the opportunity to submit comments; we especially appreciate the IRS' effort to reach out to the hospital community and better understand its concerns.

Sincerely,

Kris A. Zimmer

Kris Zimmer
Senior Vice President – Finance
SSM Health Care

From:	Susan Powell
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	FW: Sheltering Arms Hospital
Date:	Friday, September 14, 2007 1:05:13 PM
Attachments:	SAH 990 Letter.doc

From: Susan Powell
Sent: Friday, September 14, 2007 1:04 PM
To: 'Form990'
Subject: Sheltering Arms Hospital

<<SAH 990 Letter.doc>>

September 14, 2007

VIA EMAIL (Form990Revision@irs.gov) ONLY

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: COMMENTS ON PROPOSED FORM 990 AND SCHEDULES

On behalf of Sheltering Arms Physical Rehabilitation Centers, thank you for the opportunity to comment on the new draft Form 990 and its proposed schedules. We appreciate the work that the IRS has put into the new form and schedules and its openness to comments from the hospital community.

However, we do have serious concerns about the filing deadline proposed by the IRS for the implementation of the new Form 990 and its proposed schedules as well other detailed issues as described below.

THE CORE FORM AND SCHEDULES NEED SUBSTANTIAL REVISION
Significant revisions and refinements must be made to the core form, schedules and instructions. We think it is critical that exempt organizations be given an opportunity to review the revised set of forms, schedules and instructions in their entirety, with another 90-day review period following the re-draft. The IRS should release the second draft with instructions in 2008, and provide another 90-day review period, with a final form release by December 31, 2008.

It would be a disservice to the entire tax-exempt sector – hospitals in particular – to undertake the first major overhaul of the Form 990 in 25 years without adequate time for review and input. A rushed implementation schedule will inevitably require revisions and modifications that will be costly both to exempt organizations and the IRS, and that will not result in the desired transparency.

1. Core Form
• The IRS asked for comments on whether "the IRS should preclude group rulings". We understand this request was intended to elicit comments on whether hospitals and other organizations that have a "group exemption" should continue to be allowed to file a group return. Some hospital systems have received group exemptions. If group returns

are eliminated, this would result in a significant burden that subverts the underlying group exemption.

• Part I (Summary), Line 6 requires an organization to enter the number of individuals receiving compensation in excess of $100,000. This question provides information of limited use to the IRS since large organizations will likely have a larger number of individuals receiving such compensation and small organizations will likely have a smaller number.

• Part I (Summary), Line 7 requires an organization to enter the highest compensation amount reported on Part II, Section A (relating to reportable compensation paid to officers, directors, trustees, key employees, highly compensated employees and independent contractors). Requiring disclosure of the highest compensation amount paid on the summary page of the core form could mislead viewers when read outside of the context of the fuller disclosure required in Part II and Schedule J.

• Part I, Lines 8a and 8b require an organization to calculate total officer, director, trustee and other key employee compensation and then to calculate a percentage by comparing total executive compensation to total program expenses. This comparison metric provides a misleading picture of an organization's operations and should be eliminated from the form.

• Part I, Lines 19a and 19b require an organization to calculate fundraising expenses as a percentage of total contributions and grants. This percentage does not provide helpful information about an organization's operations. Notwithstanding its limited use, organizations should be given an opportunity to explain this percentage.

• Part I, Line 24b requires an organization to calculate total expenses as a percentage of net assets. This percentage is not helpful to understanding an organization's overall operations.

• Part II (Compensation and Other Financial Arrangements with Officers, Directors, Trustees, Key Employees, Highly Compensated Employees, and Independent Contractors), Section A requires information on key employees, which term is defined in part based on the disqualified person concept from the Section 4958 intermediate sanction regulations to include a "person who manages a discrete segment or activity of the organization that represents a substantial part of the activities, assets, income or expenses of the organization, as compared to the organization as a whole." Consideration should be given to defining "substantial part" or including examples in the instructions or glossary to help large organizations determine employees who would fall under the broadened definition. Hospitals could have hundreds of "key employees" if this definition is not clear.

• Part II, Section A requires an organization to list the city and state of residence of each listed individual or organization. For hospitals and heath care organizations in rural areas, providing this information could be tantamount to providing an individual's home

address.

• Part II, Section A requires an organization to include reportable compensation from "related organizations" for purposes of reporting the compensation of former (within the last five years) directors, trustees, officers and key employees or highest compensated employees. It seems overly burdensome for a large filing organization to be required to track all former directors, trustees, officers, key employees or highest compensated employees over a five-year period when they have had no need to do so in the past. Combining this requirement with a need to survey all related organizations to determine whether any individual in this group is being paid compensation by such related organization requires efforts beyond the value the information would provide. Information on former directors, trustees, officers, key employees or highest compensated employees should look to current year only.

• Part II, Section A requires an organization to use the compensation figures as reported on Forms W-2 or 1099. For hospitals whose tax year is not the calendar year, Forms W-2 and 1099 reporting will result in compensation data that is much more dated than the compensation data currently required. For example, if a hospital's fiscal year ends on June 30, the hospital would file its return on November 15, with compensation data as of December 31 of the prior year.

• Part II, Section B, Lines 5a-f require an organization to report the family and business relationships of officers, directors, trustees or key employees during a five-year lookback period. Hospital and health care organizations often have boards of directors with as many as 30 members, and hundreds of contracts. The collection and maintenance of documentation required to respond to these questions will create excessive new burdens for organizations, especially for organizations with large boards of directors. Moreover, the instructions should clarify the duties of organizations to collect such information going forward.

• Part II, Section B, Line 9 requires an organization to report whether any persons listed in Part A receive compensation from any source other than the filing organization or a related organization for services rendered to the organization. In its current form, this question requires organizations to have or acquire access to information that they may not otherwise have. This question should be clarified to address the extent to which an organization is required to seek information regarding such compensation arrangements. Also, if a listed person owns a company that is paid reasonable compensation to perform services, but the person does not receive any payment other than in his capacity as owner of the organization, what amount, if any, gets reported?

• Part III (Statements Regarding Governance, Management, and Financial Reporting), Line 2 requires an organization to report any significant changes to its organizing or governing documents. The IRS should clarify that this question would only cover changes to articles of incorporation and bylaws and not other policies of the organization.

• Part III, Line 3b requires an organization to report the number of "transactions" the

organization reviewed under its conflict of interest policy. The instructions or glossary should be revised to include a definition for "transactions." Because responding with a zero or a very high number would create a misleadingly negative connotation, and because any numerical response will have a different meaning depending on the organization and its policy, the question should be revised to ask whether the organization engaged in any transactions that were subject to the policy but were not reviewed under the policy.

• Part III, Line 10 asks whether an organization's governing body reviewed the Form 990 before it was filed. This requirement is overly burdensome, particularly for large hospital systems, which may have dozens of hospitals and related entities for which returns are being filed. The draft form does not provide a definition of "review," which should be added to the instructions or glossary. It is unclear whether an organization can simply provide the Form 990 to its governing body or whether it needs to receive some kind of certification that each member of its governing body has in fact reviewed the form. The instructions should clarify that review by the finance or an equivalent committee of an organization's governing body or the governing body of its parent organization is sufficient if the governing body delegates this function. In clarifying what is meant by "review," the IRS also should consider that boards of directors of public companies are not required to review or certify tax filings under the Sarbanes-Oxley Act.

• Part III, Line 11 asks an organization to indicate where documents are made available to the public. There is no explanation for why this is being asked.

• Part IV (Statements Regarding General Activities), Line 1d requires an organization to report the total amount of contributions received from related organizations. The instructions include as examples of related organizations, "a parent organization or affiliates at the local, state, or regional level." The example is confusing and the instructions should instead use the definition of related organizations from the glossary. Moreover, it is unclear whether all payments to related organizations (except for payments that clearly belong under membership dues, rentals, or sales) should be treated as contributions since there is no corresponding line item under "program service revenue" or "other revenue."

• Part IV, Lines 2a – 2g require an organization to enter a corresponding business code from the *Codes for Unrelated Business Activity* from the 2006 Instructions for Form 990-T for the various line items of "program service revenue." The business codes on 990-T are not broad enough to reflect accurately program service revenue.

• Part IV, Line 1c requires an organization to report contributions from fundraising events. Although the instructions use an example to show that gross income from other than contributions is to be reported on Line 11a, a reference at Line 1c to such amounts reported on Line 11a would be helpful.

• Part V (Statement of Functional Expense), Line 3 requires an organization to report expenses associated with grants and other assistance to governments, organizations, and

individuals outside of the U.S. This question does not provide a reference to Schedule F or the threshold for filing Schedule F. These references should be added.

• Part VII, Lines 8a (and the applicable instructions) requires an organization to report whether it conducted all or a *substantial* part of its exempt activities through or using a partnership, LLC or corporation and the aggregate exempt activities conducted through or by such entities involved a *substantial* portion of the organization's capital expenditures or operating budget, or a discrete segment or activities of the organization that represent a *substantial* portion of the organization's assets, income, or expenses as compared to the organization as a whole. Neither the instructions nor the glossary provide a definition, percentage or amount for the term "substantial." It is also unclear whether Lines 8a-8c would apply to passive investments of endowment or reserve funds in partnerships or publicly traded corporations.

• Part VII, Lines 11 and 12 require an organization to report whether it has a written policy or procedure for reviewing the organization's investments and safeguarding its exempt status with respect to transactions and arrangements with related organizations. To the extent the IRS intends to develop sample written policies, IRS should solicit input from members of the tax-exempt sector with respect to the content and form of such written policies.

• Part IX (Statement of Program Service Accomplishments), Lines 3a – 3c require an organization to describe its exempt purpose achievements for each of its three largest program services. This question should be moved to Part I of the form, as it is a key question. Organizations should be allowed as much additional space as necessary to describe more than three key activities. As drafted, 3d also directs organizations to attach a schedule listing other program services.

2. Schedule A (Supplementary Information for Organizations Exempt Under Section 501(c)(3))

• Part 1, Line 11f requires an organization to respond whether it has a "written determination from the IRS that it is a Type I, II or III supporting organization." Since most supporting organizations do not have written determinations from the IRS, the question as written is misleading and unfair because the IRS did not actually issue such determinations until this year. The question should allow an IRS determination or "a written opinion of counsel."

• Part 1, Line 11h, column (vii) requires an organization to report the amount of monetary support provided by the supporting organization to the supported organization(s). This question disadvantages supporting organizations such as parent holding companies within a health care system that do not pay out monetary grants or other support payments because they are functionally integrated or otherwise undertake activities in support of their supported organizations. The question should be revised to include the value of non-monetary support.

3. Schedule C (Political Campaign and Lobbying Activities)
• Part II-B requires reporting by an exempt organization, including reporting on (b) paid staff or management and for (h) seminars, conventions, speeches, lectures or any other means. It is not clear precisely what the IRS is attempting to capture under (h) and that the category needs to be so broad. Also, instead of asking for precise amounts, the IRS should ask for a range of hours, number of employees or other proxies for amounts that would provide the IRS with useful information while making the category less burdensome.

4. Schedule D (Supplemental Financial Statements)
• Parts I and III: Passive investments should be excluded from this schedule, and the listing of securities individually is extremely burdensome.

• Part VII (Other Liabilities) requires organizations to describe and list the book value of any other liabilities, including federal income tax liabilities, not reportable in the defined categories on Part VI (Balance Sheet) of the core form. Part VII also requires organizations to provide the text of the footnote to the organization's financial statements that report the organization's liability for uncertain tax positions under FIN 48. Disclosing the text of footnotes relating to uncertain tax positions in isolation could be misleading. Organizations should be given the opportunity to explain such footnotes or to attach their entire financial statement.

• Part XII (Endowment Funds) requires an organization that holds assets in term or permanent endowment funds to provide information for the past five years on fund balances, contributions, investment earnings or losses, program expenditures and administrative expenditures. The reporting burden associated with this question seems to outweigh the usefulness of this information. The five-year look-back period should be reduced or eliminated pending adoption by the IRS of reasonable standards.

5. Statement G (Supplemental Information Regarding Fundraising Activities)
• Schedule G requires an organization to report supplemental information regarding its fundraising activities. The IRS should clarify how organizations should report fundraising activities by related entities, which is a common occurrence within a health system.

6. Schedule H (Hospitals)
• The following comment and suggestion applies only to Schedule H. Physician recruitment expenses should be included within community benefit calculations to the extent that they are a part of the overall community benefit strategy.

7. Schedule J (Supplemental Compensation Information)
• Schedule J requires an organization to report supplemental compensation information with respect to listed persons from Part II of the core form. There still seems to be confusion about who gets reported on Schedule J, so the instructions should further clarify the individuals for whom such information must be reported.

• Line 1, column (C) requires an organization to report non-qualified deferred compensation. The instructions should clarify, or the schedule itself should eliminate, double-reporting of nonqualified compensation. This occurs when the amounts of unpaid, unvested deferred compensation are reported when awarded and again when they are vested. Eliminating the double reporting will give a more accurate picture of yearly compensation. The double reporting of deferred compensation is a problem under the current Form 990 and the IRS should take this opportunity to correct the confusion. This question also must address how compensation should be reported if the organization is reporting on an accrual basis.

• Line 1, column (D) requires an organization to report the amount of non-taxable fringe benefits provided to the listed persons in column (A). The instructions seem to even require reporting of de minimis fringe benefits, which by definition under the Internal Revenue Code are "so small as to make accounting for it unreasonable or administratively impracticable." The instructions should follow the current Form 990, which allows de minimis fringe benefits to be excluded. The instructions or the compensation matrix also should include examples of nontaxable fringe benefits that physicians would typically be issued as part of providing services at a hospital, e.g., pagers, cell phones and other similar items, or this requirement should be eliminated.

• Line 1, Column (E) requires an organization to report the amount of all expense reimbursements, and allowances provided for expenses, that are not included on a recipient's W-2. It is completely misleading to report such amounts on Schedule J, which is intended to disclose compensation amounts. Expense reimbursements under accountable plans that do not result in income to the recipient should not have to be reported on Schedule J.

• Lines 4 and 5 require an organization to report whether it paid compensation determined in whole or in part by the revenues or net earnings of the organization or a related organization. The instructions should clarify the types of compensation arrangements that would and would not be deemed to be determined in whole or in part by the revenues or net earnings of hospitals or health care organizations.

8. Schedule I (Supplemental Information on Grants and Other Assistance to Organizations, Governments, and Individuals in the U.S.)
Part III requires an organization to report grants and other assistance to individuals in the U.S., if the grant amount is $5,000 or more. This threshold should be increased substantially for large organizations like hospitals. The instructions and the schedule should clarify whether, consistent with the instructions to Schedule F, Part III, organizations need not complete Part III if no individual received more than the new threshold.

9. Schedule L (Supplemental Information on Loans)
Schedule L requires an organization to report details on loans to and from officers, directors, trustees, key employees, *highly* compensated employees and disqualified persons. The schedule and instructions should reference "*highest* compensated

employees" from Part II of the core form, which is also the defined term in the glossary. The use of the expression "*highly* compensated employee" is unnecessarily confusing in this context.

10. Schedule M (Non-Cash Contributions)
The threshold for completing this schedule should be increased to at least $20,000.

11. Schedule N (Liquidation, Termination, dissolution or Significant Disposition of Assets)
• Clarification is needed as to whether transfers to a wholly owned limited liability company that is disregarded as separate from the tax-exempt filing organization need to be reported.

• Clarification is needed as to whether transfers for "full and adequate consideration" that are excluded from the definition of "substantial contraction" still need to be reported as a disposition of net assets.

12. Schedule R (Related Organizations)
The following comments relate to Part V – Transactions with Related Organizations.
• For multi-hospital systems, Schedule R is extremely burdensome. At a minimum, the definition of "related" needs further review and consideration, as there are many definitions of the term that might have been used.

• Part V requires an organization to report whether it engaged in certain transactions or transfers with related organizations, including related 501(c)(3) organizations. The instructions carve out transactions between 501(c)(3) organizations where the only transactions between the organizations were gifts or grants. This instruction should be revised to allow transfers that are gifts and grants to be excluded, even where the organizations have other transactions such as leasing or services arrangements.

• The definition of "transfer" in the instructions should be revised as follows: A transfer includes any conveyance of funds or property, whether or not for consideration, *except for gifts or grants between related 501(c)(3) organizations*.

• The compliance burden from this section is of great concern to our members. Taxexempt organizations within a health system typically have numerous arrangements involving the performance of services, leasing or sharing of facilities, equipment or employees, cost reimbursement etc. By way of example, a typical 501(c)(3) health system could have hundreds of transactions to report under Part V. The AHA understands that certain questions on this schedule are in response to Section 1205 of the Pension Protection Act (PPA), but the information on transactions between related 501(c)(3) organizations should be limited to transfers that could result in UBIT under the controlled entity rule of Section 512(b)(13). Other transactions between related 501(c)(3) organizations do not raise compliance, exemption, tax or other concerns and should not need to be reported.

• Schedule R goes beyond what is required under the PPA, which at least limits reporting of transfers among “controlling and controlled” organizations. By defining “related” as including brother/sister organizations controlled by the same person or persons, Schedule R requires any exempt entity within a health care system to include all transfers between it and any other entity within the system, which completely expands the already overly broad disclosure required by the PPA. These requirements are completely unworkable in the health system setting and, again, result in the reporting of transactions that do not raise compliance, exemption, tax or other concerns.

• The instructions for column (C) require the amount involved in each transaction to be reported, which is defined as the fair market value of the services, cash and other assets provided by the organization or the fair market value received, whichever is higher. This instruction seems to require even related 501(c)(3) organizations that have cost reimbursement arrangements to determine the fair market value for these arrangements, which creates a significant valuation burden for arrangements that should not even need to be reported.

Thank you for your consideration of these comments and concerns and for the opportunity to provide feedback on the Proposed Form 990 and its schedules.

Sincerely,

James E. Sok
President & CEO

From:	Francis McLoughlin
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Community Catalyst"s Comments on Schedule H
Date:	Friday, September 14, 2007 1:04:32 PM
Attachments:	image001.jpg image002.jpg image003.jpg image004.jpg image005.jpg image006.jpg image007.jpg

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Mr. Ronald J. Schultz
Senior Technical Advisor
Tax Exempt and Government Entities Division
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

Dear Mr. Schultz:

Below please find our comments on the new Schedule H. They can also be found at http://www.communitycatalyst.org/doc_store/publications/comments_to_IRS_on_Schedule_H_9-13-2007.pdf.

Thank you,

Frank McLoughlin
Staff Attorney
Community Catalyst

++

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September 13, 2007

VIA ELECTRONIC MAIL
Mr. Ronald J. Schultz
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Tax Exempt and Government Entities Division
Internal Revenue Service
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Re: Comments on the Proposed Redesigned Form 990 and New Schedule H

Dear Mr. Schultz:

Thank you very much for providing us with this opportunity to comment on the proposed redesigned Form 990 and the new Schedule H. Our comments in this letter will be focused primarily on Schedule H.

We represent health care consumer organizations from across the United States that are working to ensure that all stakeholders in the health care system -- including federal, state, and local governments; hospitals; and health insurers – assume their fair share of the obligation to provide quality, affordable health care for all.

First, we want to express our appreciation for your efforts to redesign Form 990. As you know,

We represent health care consumer organizations from across the United States that are working to ensure that all stakeholders in the health care system -- including federal, state, and local governments; hospitals; and health insurers – assume their fair share of the obligation to provide quality, affordable health care for all.

First, we want to express our appreciation for your efforts to redesign Form 990. As you know, the public often looks first to Form 990 for information on how nonprofit institutions are performing and on how they measure up against each other in serving their communities. Because the proposed new Form 990 would increase transparency, and promote greater clarity and uniformity in reporting, your office's efforts represent a valuable public service.

Second, we want to make it clear that, beyond the redesign of these forms, there is still much more to be done. Although the new Form 990 and Schedule H will give both your office and the public a much better picture of whether nonprofit hospitals are living up to their obligations as tax-exempt institutions, there will still be a need to raise and clarify the standards under which hospitals earn this exemption. As your office has recently found,[1] and as the office of Senator Chuck Grassley has also noted,[2] too many tax-exempt hospitals are falling short in the provision of charity care and community benefits without consequence to their tax-exempt status. It is our hope that the introduction of Schedule H will help all sides in promoting a debate on establishing firm, meaningful standards on charity care and community benefits.

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[1] Internal Revenue Service, Hospital Compliance Report, Interim Report. (http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report_072007.pdf)

[2] Office of Senator Chuck Grassley, Ranking Member of the Senate Committee on Finance, "Tax Exempt Hospitals: Discussion Draft", posted on July 18, 2007. (http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf) [hereinafter "Discussion Draft"]

The Crisis in Charity Care and Community Benefits

Charity care is often the only option for uninsured and underinsured persons or families in the United States.[3] And yet, many hospitals have failed to develop and implement an adequate charity care policy. The two recently issued reports noted above powerfully state that far too many of these tax-exempt, charitable institutions are not providing their fair share of charity care and community benefits to the communities they are meant to serve. The report issued by your office shows that more than 20% of tax-exempt hospitals provide less than 1% of the value of their revenues in uncompensated care.[4] The report issued by the office of Senator Grassley states that a significant number of nonprofit hospitals have been failing to provide sufficient levels of charity care, and suggests that all tax-exempt hospitals be required to provide annual charity care with a minimum value of 5% of the hospital's gross revenues or patient operating expenses, whichever is greater.[5]

This problem is compounded by the tendency of some hospitals to not sufficiently and appropriately publicize the existence of their charity care policies. In some cases, tax-exempt hospitals have denied that they provide any charity care.[6] Fearing high medical bills, many who might qualify for full or partial charity care instead refuse to seek treatment, usually resulting in greater illness and higher medical costs later on.[7] When people do seek treatment, some hospitals, without adequately attempting to determine whether a patient is eligible for charity care, engage in aggressive debt collection practices, which can destroy the financial security of the uninsured or underinsured patient.[8]

The Importance of Transparency

We recognize that there are many issues of great debate on the role of tax-exempt hospitals in our communities and in our nation's health care system. But the public cannot fully participate in these debates without access to the vital, and vitally relevant, data sought in Schedule H. With the modifications that we suggest in this letter, Schedule H will become a valuable tool for the public, policymakers, hospitals, and other health system stakeholders as we attempt to debate the best way to resolve the crisis in charity care and community benefits.

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---

[3] Community Catalyst, "Not There When You Need It: The Search for Free Hospital Care," October 2003, p. 29. (http://www.communitycatalyst.org/doc_store/publications/not_there_when_you_need_it_the_search_for_free_hospital_care_oct03.pdf)

[4] Internal Revenue Service, Hospital Compliance Report, Interim Report, p. 24.

[5] Discussion Draft, p. 7. The Discussion Draft also proposes several other reforms that would heighten both transparency and accountability in the nonprofit hospital sector. (http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf) [hereinafter "Discussion Draft"]

[6] "Not There When You Need It," pp. 17-18. This section describes the discouraging results when community monitors contacted hospitals from around the country and attempted to learn if charity care were available.

[7] Id. at 29.

[8] Gerard F. Anderson, "From 'Soak the Rich' To 'Soak the Poor': Recent Trends in Hospital Pricing, Health Affairs May/June 2007, Vol. 26, No. 3, pp. 784-5; citing D.U. Himmelstein et al, "Illness and Injuries as Contributors to Bankruptcy," Health Affairs Vol. 24 (2005).

Schedule H, Part I: Community Benefit Report

We support your office's use of the Catholic Health Association's (CHA's) reporting guidelines as a model for reporting community benefits. This model affirms what many other health system stakeholders, including many tax-exempt hospitals, have recognized: that a meaningful charity care and community benefits program is an absolutely essential part of a nonprofit hospital's mission. The Community Benefit information that the new Schedule H requires will shine a powerful light on those hospitals that excel in serving their communities -- and those that are falling short.

Column (a): "Number of activities or programs" and Column (b): "Persons served"

Although the data sought in columns (a) and (b) might not be essential in seeking information on "Other Benefits" (lines 5-9), we hope that that your office will retain the requirement that hospitals report not only the dollar amount of charity care provided,[9] but also the number of persons served by the hospital's charity care program. Reporting the number of persons served will provide the public with a much fuller picture of whether tax-exempt hospitals are doing enough to publicize and make available charity care to those who might be eligible for such care.

Lines 5-9: Definition of "Other Benefits"

There is a great debate about what constitutes a "true" community benefit. In many cases, programs and activities that fit within the categories of "Other Benefits" described in lines 5 through 9 of Part I would fall under the definition of community benefit. However, we believe that some activities that might fit within these categories, such as research activities that are so broad that they will provide no direct benefit to the hospital's targeted community, should not be considered a community benefit.[10] Some other community activities conducted by hospitals, which would not fall within the categories listed on lines 5-9, such as sponsoring a section of a local highway, while laudable, would also not have a sufficient connection to a hospital's charitable health mission to be considered a community benefit. On the other hand, we also believe that there are instances when programs and activities not accounted for in lines 5-9 could still be considered a community benefit.

which would not fall within the categories listed on lines 5-9, such as sponsoring a section of a local highway, while laudable, would also not have a sufficient connection to a hospital's charitable health mission to be considered a community benefit. On the other hand, we also believe that there are instances when programs and activities not accounted for in lines 5-9 could still be considered a community benefit.

We believe that in order to report programs and activities as "other benefits," a hospital must demonstrate that such programs or activities 1) stem from a properly conducted community health needs assessment, and 2) target the underserved and medically vulnerable in the community.[11] We would therefore recommend that an additional line be included in the "Other

[9] We agree with the CHA that dollar amounts of charity care and community benefits should be measured and reported using a standardized cost-to-charge ratio.
[10] Community Catalyst, "Commentary to the Health Care Institution Responsibility Act," p. 7. (http://www.communitycatalyst.org/doc_store/publications/commentary_to_the_health_care_institution_responsibility_model_act_1999.pdf)
[11] See Community Catalyst's "Health Care Institution Responsibility Model Act" for a more detailed discussion of the definition of a community benefit, including a list of examples. (http://www.communitycatalyst.org/doc_store/publications/the_health_care_instititution_responsibility_model_act_1999.pdf)

Benefits" portion of the chart that would enable hospitals to report all other community benefit programs and activities that meet these strict standards.

Line 13b: Description of the hospital's charity care policy

We welcome the requirement that hospitals provide a detailed description of their charity care policies. But we are concerned that this reporting requirement, as currently worded, will not elicit information important to assessing the performance of a hospital, or to comparing hospitals. We would therefore recommend that your office add a question that requires hospitals to describe in detail the specific criteria they use to determine patient eligibility for charity care.

We also recommend that your office require hospitals to state which services are included, or excluded, under their charity care policies. For instance, are only emergency services covered? Or do hospitals include non-emergency services, and if so, which services?

We would also suggest that your office add a separate but similar set of questions in this section regarding partial charity care. A tax-exempt hospital's approach to partial charity care is often one of the most important issues facing the underinsured.

Part II: Billing and Collections

This new section is an important and useful addition to the Form 990 process. For the first time, the public will be able to access hard, uniform data showing how hospitals serve all classes of patients – from those who are privately insured, to those who receive Medicare, Medicaid, and other government programs, to the uninsured. We would add that we do not believe that collecting and reporting this information would be unduly burdensome to a hospital. It is our understanding that many tax-exempt hospitals already collect this information for their own purposes.

Medicare Shortfall

We recognize that there is great debate regarding how a hospital's Medicare shortfall should be reported. As you know, the CHA does not consider the Medicare shortfall to be a community benefit. Whether it is considered a community benefit or not, we think that this information is an important part of the debate and should be required to be reported.[12] It is worth adding that, in the event that a hospital ended a particular year with a Medicare surplus, as opposed to a

Medicare Shortfall

We recognize that there is great debate regarding how a hospital's Medicare shortfall should be reported. As you know, the CHA does not consider the Medicare shortfall to be a community benefit. Whether it is considered a community benefit or not, we think that this information is an important part of the debate and should be required to be reported.[12] It is worth adding that, in the event that a hospital ended a particular year with a Medicare surplus, as opposed to a shortfall, a Medicare-specific reporting requirement would also capture this fact.

Bad Debt and Collection Practices

The CHA model is also useful because it makes clear that which must not be considered a community benefit. "Bad debt" has been widely recognized not to represent a true community benefit. We understand that there are cases when a hospital might have difficulty ascertaining a patient's eligibility for charity care upon admission. Unfortunately, however, too many hospitals

[12] The size of all shortfalls should be measured using an appropriate methodology, such as by using an actual reimbursement-to-charge ratio.

have adopted a "bill first, ask questions later (if at all)" policy that wreaks havoc on the financial and emotional wellbeing of the medically vulnerable and their families. The quality and humaneness of a hospital's debt collection policy and practices, particularly as they relate to a hospital's determination of charity care, are a key factor in determining whether a hospital is fulfilling its obligations as a community benefit provider.

We also recommend that, should your office require the reporting of bad debt anywhere on Schedule H, there should also be a requirement that the hospital report emergency room- and non-emergency room-related bad debt separately. This information is often very useful in determining the effectiveness of a hospital's overall charity care policy.

Part III: Management Companies and Joint Ventures

We applaud your office's focus, both within the proposed redesigned Form 990 generally, and within Schedule H, on the potentially harmful effects of joint ventures between tax-exempt hospitals and for-profit entities. In the past, some joint ventures between nonprofit and for-profit institutions have resulted in a *de facto* conversion of charitable assets to non-charitable use. It is our hope that Part III, as currently formulated, will call attention to any hospital that attempts in the future to divert its charitable resources for private, profit-making purposes.[13]

Part IV: General Information

Each of the four lines in Part IV seeks important information about a hospital's record of service to the community. For example, the development of a community health needs assessment, and the manner in which it is developed, are important aspects of a community benefits program. Line 1 will enable the public and policymakers to compare the community assessment processes of different nonprofit hospitals, discover best practices among hospitals, and work to establish higher standards in this area for all hospitals.[14]

Line 2 requires hospitals to address another key issue. As we noted earlier, some tax-exempt hospitals are not doing enough to publicize their charity care policies, and to educate patients about their eligibility for charity care or other medical assistance.[15] There no longer is an obligation under the Hill-Burton Act requiring hospitals to publicize their charity care policies.[16]

[13] The office of Senator Grassley makes some useful suggestions regarding ways in which charitable assets and a nonprofit's charitable mission might be preserved following a joint venture. See Discussion Draft, pp. 10-12. See also, Community Catalyst, "A Conversion Model Act," particularly Section 15 on joint ventures. (http://www.communitycatalyst.org/doc_store/publications/a_conversion_model_act_oct03.pdf)

[14] Such an assessment should take into account existing data from other community health or public agencies, attempt to identify institutional or systemic reasons for a community's poor health status, target the medically

obligation under the IRS Bureau Act requiring hospitals to publicize their charity care policies.

[13] The office of Senator Grassley makes some useful suggestions regarding ways in which charitable assets and a nonprofit's charitable mission might be preserved following a joint venture. See Discussion Draft, pp. 10-12. See also, Community Catalyst, "A Conversion Model Act," particularly Section 15 on joint ventures. (http://www.communitycatalyst.org/doc_store/publications/a_conversion_model_act_oct03.pdf)

[14] Such an assessment should take into account existing data from other community health or public agencies, attempt to identify institutional or systemic reasons for a community's poor health status, target the medically underserved, and should re-assess existing community benefit programs and activities conducted by the hospital. Community Catalyst, "Commentary to the Health Care Responsibility Model Act", pp. 8-9. See, e.g., Baystate Medical Center FY 2006 Community Benefits Report, pp. 2-4, for a description of that hospital's effective community health needs assessment process. (http://baystatehealth.com/forms/pdf/FY_2006_BMC_Community_Benefits_Report.pdf)

[15] See generally "Not There When You Need It." For a positive example, see the webpage of the North Shore-Long Island Jewish Health Care Access Center, (http://www.northshorelij.com/body.cfm?id=565&oTopID=565&PLinkID=1360.)

[16] Anderson, "From 'Soak the Rich' To 'Soak the Poor'," p. 784.

It is our hope that, by requiring hospitals to answer Line 2, hospitals that are not doing enough to educate patients in need will begin to improve this aspect of their service to the community.

Overall, the answers to these questions will do more than educate the public. It is our hope that being required to provide this information will challenge all tax-exempt hospitals to raise their standards in these important areas.

Additional Issues

Filing by Institution versus Filing by Group of Institutions

One objection that we have to the proposed Form 990 is that is appears to allow a hospital system to report as one unit. We are concerned that this would prevent the public from getting an accurate picture of how hospitals in their particular communities are performing. It is not unusual for health care systems to control hospitals in urban, suburban, and rural areas, with different patient mixes and different levels of commitment to charity care and community benefits. Furthermore, we do not believe that requiring hospitals to report individually would be unduly burdensome. It is our understanding that hospital systems already collect this information on an institution-by-institution basis for their own uses. We would therefore strongly urge your office to require hospital systems or other entities that control more than one exempt hospital to submit a separate Schedule H for each hospital in the system.

Schedule H Rollout and Implementation

We recognize that the revised Form 990 and the range of new and revised Schedules that your office is proposing will require some retooling of the record keeping and reporting practices of nonprofit organizations. However, we feel strongly that Schedule H, at a minimum, should be rolled out in time for calendar year 2008, for filing during 2009. Most, if not all, of the data required to complete Schedule H, such as levels of charity care and other community benefits, should already be compiled by hospitals, or should at least be relatively straightforward to compile.

The Importance of the New Schedule H

As your office clearly recognizes, Form 990 is meant for everyone. It is not merely meant for accountants, lawyers, and health care professionals. Especially in the Internet (and GuideStar) age, it cannot be overemphasized that the public depends upon Form 990 to provide important information about the nonprofit institutions that serve their communities. Schedule H, with its basic questions about hospital practices, and clear categories for reporting community benefits and billing, will allow people to assess how well their hospitals are serving their communities, and to engage in the great debate on how to enhance access to quality, affordable health care. Again, we hope that these positive developments on the reporting front will also lead to the

accountants, lawyers, and health care professionals. Especially in the Internet (and GuideStar) age, it cannot be overemphasized that the public depends upon Form 990 to provide important information about the nonprofit institutions that serve their communities. Schedule H, with its basic questions about hospital practices, and clear categories for reporting community benefits and billing, will allow people to assess how well their hospitals are serving their communities, and to engage in the great debate on how to enhance access to quality, affordable health care. Again, we hope that these positive developments on the reporting front will also lead to the creation of more meaningful standards for tax-exempt hospitals' charity care and community benefits policies.

We look forward to working with your office as the redesign process continues.

Thank you,

Frank McLoughlin
Staff Attorney
Community Catalyst

Renée Markus Hodin
Project Director
Community Catalyst

Also on behalf of:

TakeAction Minnesota
St. Paul. Minnesota

TexPIRG
Austin, Texas

Nebraska Appleseed Center
for Law in the Public Interest
Lincoln, Nebraska

Coalition for Citizens with
Disabilities of Mississippi
Jackson, Mississippi

Healing the Children FL-GA
Palm Coast, Florida

Maternity Care Coalition
Philadelphia, Pennsylvania

ACORN – Association of Community
Organizations for Reform Now
New Orleans, Louisiana

Subcommittee on Free Care Monitoring
Project – Galveston Co. Cancer Coalition
Galveston, Texas

Progressive States Network
New York, New York

The Artists Foundation
Boston, Massachusetts

Oregon Health Action Campaign
Salem, Oregon

Consumers for Affordable Health Care
Augusta, Maine

Universal Health Care Action Network of Ohio
Columbus, Ohio

Virginia Poverty Law Center
Richmond, Virginia

Independent Living Resource
Concord, California

Florida CHAIN
Plantation, Florida

Maine Equal Justice
Augusta, Maine

Community Service Society
New York, New York

The Access Project
Boston, Massachusetts

Families USA
Washington, District of Columbia

cc: Senator Max Baucus, Chairman, Senate Committee on Finance

Augusta, Maine

New York, New York

The Access Project
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Senator Chuck Grassley, Ranking Member, Senate Committee on Finance
Secretary Henry M. Paulson, Jr., Department of the Treasury

From:	Audrey Stromberg
To:	*TE/GE-EO-F990-Revision;
CC:	Bob Olsen; Carolyn Casterline;
Subject:	Form 990 comments
Date:	Friday, September 14, 2007 12:56:52 PM
Attachments:	Form 990 comment ltr.doc

Please read the attached Form 990 comments.

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September 14, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Ave., NW
Washington, D.C. 20224

RE: Comments on Draft Redesigned Form 990 and Schedules

I am writing on behalf of Roosevelt Medical Center, a 25-bed CAH, which is the only health care facility serving Culbertson, Montana, and the surrounding area. Roosevelt Medical Center is a government entity by virtue of the Culbertson Hospital Tax District and operates as a private, 501(c)3 non-profit entity.

The proposed additional reporting requirements, as outlined, place undue hardship and more unreimburseable cost burden on small hospitals. We don't use VHA or CHA programs to measure public benefit because of the high cost and lack of staff to complete the extensive data requirements. Much of what is being asked is "transparent" because we are a tax-supported entity and subject to all Board meetings and financial records being open to the public.

The Critical Access Hospital designation was developed to keep health care access in rural and frontier communities across the country. Facilities like RMC, who are subject to low patient volumes and a high percentage of Medicare cost-based reimbursement, struggle with cash flow and cannot absorb additional .5-1.0 FTE staffing or $6000-$10,000 in software costs to track benefits that are obvious to the communities we serve. I recommend that CAHs be exempted from community benefit reporting requirements as proposed and that the IRS works directly with representatives from hospitals with less than 25 beds to establish reporting metrics that make sense for these sole community hospitals.

I completely support the comments submitted by MHA, as association of Montana Health Care Providers, regarding the changes to Form 990 and supporting schedules.

Thank you for this opportunity to comment and for giving this issue your full consideration. If you have questions, please contact me.

Sincerely,

Audrey Stromberg, Administrator

(Submitted by Electronic Filing)

From:	Pamela Gray
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Comments on Proposed New Form 990
Date:	Friday, September 14, 2007 11:45:54 AM
Attachments:	IRS comment letter - 2008 changes.doc

Attachment

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September 13, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: COMMENTS ON PROPOSED NEW FORM 990

On behalf of Henry Ford Health System, thank you for the opportunity to comment on the new draft Form 990. We are writing now because we understand that the Internal Revenue Service (IRS) is requesting early comment on the forms and plans several rounds of changes.

We appreciate the work that the IRS has put into the new form and schedules and its openness to comments from the health care community. However, we have serious concerns about several elements of the proposed Form 990 and in particular Schedule H.

GENERAL

We believe that all financial information required to be presented on Form 990 should be required to comply with Generally Accepted Accounting Principles in the United States (GAAP). This will enhance the ability to compare information and reduce the burden of gathering information. GAAP already encompasses rigorous requirements as to content and presentation and is well understood by most users of financial information. It is impractical to attempt to develop another basis for reporting financial information solely for purposes of Form 990.

The interrelationship between the new proposed forms and the related instructions is confusing. Cross referencing to the instructions should be made highly logical to ensure that preparers and users of the forms consistently interpret the required and reported information. The proposed instructions are quite lengthy, at times recite regulations, and provide “tips” that are intended to be helpful, but may act to confuse. The numbering and sequencing of the forms and instructions does not always allow for quick reference. Without this ability, many users will default to what they think is the intent of the form, rather than seeking guidance

Since, unlike other tax filings, Form 990 is a public document and serves as a primary source of communicating program initiatives to the public, we strongly believe that greater ability to describe programs or attach related documents should be provided.

The differentiation of compensation matters between “Officers, directors and Key employees” and “Disqualified persons” is confusing. The form should utilize one clear definition for all compensation disclosures.

Use of IRS prescribed ratios to presumably evaluate the efficiency of operations or programs should be avoided. Analysts should be allowed to utilize their own basis for evaluation. Such ratios (fund raising or compensation for example) may actually be misleading without the ability of the organization to include sufficient explanatory language.

Part I
More space should be provided to list key programs, and clearer guidance offered to assist in determining the basis upon which to determine this disclosure. This can be very significant information, so it should not be reduced to one line.

The focus on gaming and fundraising as common measures of the programs should be eliminated or minimally, allowance for discussion should be provided.

Part II
Although the disclosure requirement does not extend to providing the full home address of each the names individuals, the information (City and State) in most cases would be sufficient in many cases to enable identification of the specific residence. It is unclear why this is useful information.

Compliance disclosures requested related to "covered relationships" is impractical as it is currently defined. Narrowing of the definition or the involved parties should be considered.

Part V – PAYMENTS TO AFFILIATES
There needs to be much greater clarity with regard to the intent of this disclosure. Large organizations most typically have numerous shared services provided between linked entities that flow through inter-company accounts. Quantification of this in aggregate would be meaningless and could act to conceal activities of a greater concern.

SCHEDULE H
Within the Henry Ford Health System are several hospitals- serving diverse communities, as well as the Henry Ford Medical Group – one of the largest medical group practices in the country and several other businesses involved in the provision of health services to the community. Instructions related to the new Hospital Schedule H should clarify if it applies only to acute hospital inpatient services. Additionally, it should allow greater flexibility to address the great diversity of community benefits we provide.

Based on our initial reviews, we have three primary concerns with Schedule H that we are asking the IRS to address:

- The filing deadline for Schedule H is far too short and should be extended;

- The full value of hospital community benefit is not included in Schedule H and should be; and
- The IRS is requesting information that is unrelated to community benefit and that will not be meaningful to the public. It should be removed from the form.

We strongly recommend that implementation be delayed until 2010 to accommodate the delay the IRS anticipates in issuing instructions, as well as the need to adjust or create systems to capture the required measurements and financial information.

We are committed to transparency. However, the burden of having to reconfigure financial and data record-keeping systems in time to begin capturing the substantial amount of data required just for the Part I Community Benefit Report by January 1, 2008, is itself a daunting task. It is made virtually impossible by the fact that the instructions, definitions and worksheets needed to collect that data are not expected to be finalized until mid-2008. To require hospitals to overhaul financial and data recordkeeping systems before the definitions, line item instructions and worksheets for making the calculations required for Schedule H are completed is unreasonably costly and disruptive.

Given the number of questions and concerns about Schedule H that have surfaced, we would urge the IRS to consider providing a second draft in 2008 and another review period toward the goal of finalizing the schedule in December 31, 2008. That would give hospitals sufficient time to revise their financial and data record-keeping systems in order to track and capture new information that will need to be reported.

Hospitals qualify for the charitable purpose of promoting health by meeting the community benefit standard. The community benefit standard permits us to tailor our programs and services to the needs of various individual communities. Among those needs is providing care for low-income patients who may not be able to afford the costs of their care. Yet we provide their care proudly, and the costs we absorb in doing so should be reflected as a community benefit on Schedule H.

As currently drafted, Schedule H does not count patient care bad debt expenses as community benefit. We know that a significant majority of bad debt is attributable to low-income patients, who for many reasons decline to complete the forms required to establish eligibility for either our charity care or fee discount programs

A 2006 Congressional Budget Office report cited two studies indicating that "the great majority of bad debt was attributable to patients with incomes below 200 percent of the federal poverty level." The fact is that despite our best efforts, many of our patients still do not identify themselves as in need of financial assistance. It is important to us and to our community that the full cost of serving our community – including the cost of serving patients who

need help paying their bill but fail to ask for it – be recognized and counted as community benefit.

Additionally, the proposed chart on Schedule H, Part II relating to billing should be eliminated. It has no bearing on determining whether a hospital is meeting the community benefit standard, and it should not be used to create new reporting standards.

Relevant information is already provided in other parts of the Form 990. For example, detailed information on charity care will be provided in Part I of Schedule H. Information related to a hospital's revenues and Medicare and Medicaid payments will be included in Form 990.

Beyond that, the chart's added layers of requests will require extra staff work to provide, some of the information requested may be competitively sensitive and the chart displays information in a form that is likely to confuse, not inform, our community.

If the IRS requires more information on our charity care policies and practices, or the way in which we support other community benefit activities and programs, it should ask those questions instead of creating new reporting obligations that would be burdensome and will confuse our communities instead of providing them with the information they need to determine whether we are serving their needs.

Thank you for the opportunity to comment on the draft Form 990.

Sincerely,

J. Douglas Clark
Vice President

From:	sduke@midrivers.com
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Form 990 Comment Letter
Date:	Friday, September 14, 2007 11:36:42 AM
Attachments:	IRS Form 990 Letter.doc

Please find attached IRS Form 990 comment letter. Thank you.

Teton Medical Center

915 4th St. N.W.
Choteau, Montana 59422
(406) 466-5763
www.tetonmedicalcenter.net

Glendive Medical Center

September 14, 2007

By Electronic Filing

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: COMMENTS ON DRAFT REDESIGNED FORM 990 AND SCHEDULES

Hello, my name is Scott A. Duke, Chief Executive Officer for the Glendive Medical Center (GMC) located in Glendive, Montana. I am also the current Chairman for the Montana Hospital Association (MHA). As such, I appreciate the opportunity to submit comments on the draft redesigned Form 990.

GMC is a not-for-profit, community-based health care organization that provides a full spectrum of medical services. Specifically, GMC is comprised of a 25 bed critical access hospital (CAH), 75 bed skilled nursing facility, 13 unit assisted living facility, along with a home care/hospice agency that serves 4 area counties. GMC also operates and manages the Eastern Montana Veteran's Nursing Home, an 80 bed skilled nursing facility. In addition, 22 physicians and mid-level providers practice at our facility and provide outpatient services at the Gabert Clinic, which is a federally designated rural health clinic (RHC). GMC employs more than 450 people.

By most standards, GMC is considered a small rural hospital but, it is important to note that in Montana there are 45 CAH's and most of these facilities are significantly smaller in their size (number of beds and scope of services). These facilities are sometimes referred to as "Frontier" hospitals.

Since 1999, GMC has voluntarily reported its community benefits, following the model established by the Volunteer Hospital Association, Inc. (VHA). Montana's hospitals recognize the importance of publicly demonstrating that we are fulfilling our charitable responsibilities and we believe that our community benefits report provides the amount of information which is practical for an organization of our size.

It is always difficult to make one solution "fit" all types of entities particularly hospitals. The CAH program was designed to maintain access in rural and frontier parts of the United States. CAH's face many challenges and can struggle with low patient volumes and financial issues and by the nature of our size; CAH's are some of the most transparent hospitals in our country. It is with this in mind that I share the following comments, concerns, and recommendations related to the proposed changes to the Form 990 on behalf of GMC and MHA which represents all hospitals in Montana.

- **The proposed reporting requirements would impose an unreasonable burden on hospitals, especially critical access hospitals.**

    - The proposed changes would substantially alter the Form 990 and create 15 new reporting schedules for tax-exempt organizations, including hospitals. MHA staff estimates that Montana hospitals may have to complete as many as eight of these forms.
    - Critical access hospitals are least able to comply with the new reporting requirements, especially Schedule H which would require them to quantify the community benefits they provide.
        - CAH's have minimal staff in their billing and business offices.
        - CAH's do not have staff trained to compile community benefit information, nor do they have the software needed for this task.
        - MHA members estimate that compliance would require 120-160 hours a year of staff time. This does not include the time required to install and train staff on how to compile the data.
        - The software used by CHA and VHA hospitals to compile community benefit data costs more than $6,000 to purchase. In addition, annual update fees are charged. Only one of Montana's 45 CAH's uses this software currently.

    - **Recommendation:** Either to exempt CAH's from the community benefit reporting requirement or to significantly scale back this requirement.
        - The continued operation of CAH's – providing the only access to health care in frontier communities – should justify their community benefit.
        - Instead of quantifying their community benefit, as proposed by the IRS, CAH's could be required to list the community benefits they provide. This would ensure accountability while also avoiding the extra administrative burden.

- **The Definition of Community Benefit should include unpaid Medicare costs and bad debt.**
    - Providing medical treatment for the elderly and serving Medicare beneficiaries is an essential service provided by hospitals – regardless of the amount hospitals are paid for doing so.
    - Medicare's payments to hospitals do not cover the full cost of the care provided to Medicare beneficiaries. Nationwide, Medicare pays hospitals about 92 cents for every dollar of care they provide. MedPAC data substantiate the point that hospitals are losing money treating Medicare beneficiaries; MedPAC estimates that these losses are expected to grow in the future.
    - Medicare pays CAH's 101 percent of what it considers cost. However, Medicare excludes a number of costs; as a result, CAH's are really paid only 90-95 percent of cost.
    - Unpaid Medicare costs amount to a subsidy hospitals provide to the Medicare program and are a substantial community benefit.
    - Much of the bad debt incurred by hospitals is for care delivered to low-income, uninsured and underinsured patients, who, for whatever reason; decline to apply for financial assistance. We serve these patients regardless of their ability to pay – which certainly qualifies as a community benefit.
    - In a 2006 report, the Congressional Budget Office concluded that its study supports using uncompensated care (bad debt and charity care) as a measure of community benefits.

- **The IRS wants to collect pricing information that is not relevant to the charitable purpose of a hospital**.
    - The pricing matrix contained in Schedule H, Part II is unnecessary. Charity care data is included in Schedule H; Part I. Information about a hospital's Medicare and Medicaid revenues is also contained in other parts of the form.
    - Private pay pricing and discount information is proprietary. Disclosing it could give insurers a competitive advantage in negotiating contracts.

- **The IRS delay implementation of the forms and schedules – in particular, Schedule H – until tax-year 2010**.
    - It is unrealistic to think that hospitals can begin compiling such a massive amount of information beginning on January 1, 2008. It will be difficult for the IRS to publish guidelines by then, difficult for hospitals to revise their software and difficult for hospitals to train their staff for compliance.
    - A delay also would give the IRS more time to work with hospitals to improve the transition to the new forms and schedules.

The Definition of Community Benefit should include unpaid Medicare costs and bad debt.
Providing medical treatment for the elderly and serving Medicare beneficiaries is an essential service provided by hospitals – regardless of the amount hospitals are paid for doing so.

Medicare's payments to hospitals do not cover the full cost of the care provided to Medicare beneficiaries. Nationwide, Medicare pays hospitals about 92 cents for every dollar of care they provide. MedPAC data substantiate the point that hospitals are losing money treating Medicare beneficiaries; MedPAC estimates that these losses are expected to grow in the future.

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Much of the bad debt incurred by hospitals is for care delivered to low-income, uninsured and underinsured patients, who, for whatever reason; decline to apply for financial assistance. We serve these patients regardless of their ability to pay – which certainly qualifies as a community benefit.

In a 2006 report, the Congressional Budget Office concluded that its study supports using uncompensated care (bad debt and charity care) as a measure of community benefits.

Collecting Pricing Data
The IRS wants to collect pricing information that is not relevant to the charitable purpose of a hospital. The pricing matrix contained in Schedule H, Part II is unnecessary. Private pay pricing and discount information is proprietary. Disclosing it could give insurers a competitive advantage in negotiating contracts.

The data collected on a historical basis will serve no useful public function. The Form 990 is not an appropriate tool for the public to seek current pricing information about their health care. The Centers for Medicare and Medicaid Services is already working to post price and quality data on the Internet for common services. The effort by the IRS is redundant, at best.

Since the Form 990 is collecting historical data, the pricing information is out-of-date. Consumers need access to pricing and quality information. But that data is best obtained directly from the medical providers being considered by the consumer.

In closing, I want to thank you again for the opportunity to provide these remarks and for your serious consideration of the same. If I can be of further assistance please feel free to contact me.

Sincerely,

Scott A. Duke
Chief Executive Officer

From:	Marjorie Parker
To:	*TE/GE-EO-F990-Revision;
CC:	Rick L. Gundling; Laura E. Noble;
Subject:	Comments on proposed redesigned From 990
Date:	Friday, September 14, 2007 11:31:19 AM
Attachments:	Notebook.jpg 400581-Comment letter-IRS Form 990.pdf

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Marjorie Parker
hfma
Office Manager
202.296.2920, ext. 608 ***l*** _____

September 14, 2007

By Electronic Filing

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: Comments on Draft redesigned form 990 and Schedules

The Healthcare Financial Management Association (HFMA) is pleased to submit the following comments on the draft redesigned Form 990 and new draft schedules.

These reporting documents have the potential to help tax-exempt healthcare providers better tell their community benefit story and demonstrate that they are fulfilling their tax-exempt purpose. Revising the form and adding a schedule to reflect today's complex healthcare environment is timely and laudable. We look forward to working with the IRS and our membership to ensure that these reporting tools achieve the stated goals of transparency and accountability while minimizing administrative burden.

Over the past several months, HFMA has worked closely with members, other healthcare organizations, and IRS staff on this issue. We observe that the tax-exempt healthcare community is closely aligned on their concerns about the extent of revisions that must be made to the redesigned Form 990 and new schedules (particularly Schedule H) before they become effective tools to promote transparency, comparability, and accountability. The American Hospital Association, American Bar Association, Catholic Healthcare Association, and others have submitted comments that provided detailed, line-by-line recommendations. Rather than repeat their work, we wish to express our concurrence with the common themes and recommendations submitted by our colleagues. In this letter, we will limit our remarks to those points that are specific to HFMA's expertise and positions.

Attributes of Tax-Exempt Healthcare Providers

We are delighted to see that the form and schedule clearly reflect the fact that charitable activity extends well beyond the provision of charity care, as provided for by IRS Revenue Ruling 69-545.

Tax-exempt healthcare organizations are formed to address the specific needs of their communities; therefore, the attributes that merit tax-exemption are not standard across all institutions. In 1991, an HFMA Chairman's Task Force released a report identifying the major attributes of tax-exempt organizations. The Principles and Practices Board built on these attributes in light of the current environment. These attributes can be divided into organizational characteristics and types of services.

Organizational characteristics:

- Mission to Provide Community Benefit. Mission is a cornerstone of granting tax-exemption. According to federal law, the tax-exempt provider must have a clearly defined mission statement committing the institution to charitable endeavors. Both the institution's historical background and the community's needs are important in determining the mission statement.

- Use of Financial Surpluses. No individual may receive any portion of a tax-exempt institution's financial surpluses as a result of ownership. Both federal and state laws require that all financial surpluses must go toward furthering the organization's charitable purpose. Compensation arrangements must be carefully constructed to reflect fair market value for services rendered.

- Accountability. The organization's board of trustees must hold itself answerable to its community for maximizing the entity's contribution to the community.

- Goodwill. Goodwill is an intangible attribute characteristic of successful tax-exempt hospitals continuing their mission of providing care and meeting their community responsibility over a long period of time. Such organizations usually have stable ownership and governance structures and regularly receive significant philanthropic and volunteer support.

Types of charitable services:

- Provision of Charity Care. Free or discounted care is an important component of many hospitals' tax-exempt missions, but is not the only function that hospitals perform to merit tax-exempt status. Organizations that provide charity care must establish and communicate a clear charity care policy based on community needs and input. The policy should include easy-to-understand, written eligibility criteria.

- Reduction of Government Burden. Many tax-exempt hospitals provide services that government otherwise would have to provide. Services especially demanded from tax-exempt healthcare providers include high-tech, high-intensity services, emergency care, chronic care, long-term care, and unprofitable services.

- Provision of Essential Healthcare Services. Tax-exempt healthcare providers are often the sole providers of healthcare services that are so essential to community health that tax-exempt status is warranted. Examples of essential services include emergency rooms and outpatient clinics serving low-income patients.

- Provision of Unprofitable Services. The provision of unprofitable services is commonly a provider's charitable response to a community need. Unprofitable services in this sense lose money because of high costs combined with low volume or inadequate payment rather than inefficient operations. Common examples of unprofitable services include burn, neonatal, and trauma centers and community mental health centers.

- Public Education. Teaching institutions, of course, are exempt because of their role in the advancement of education and science. Most tax-exempt healthcare providers, however, also provide a range of educational programs to enhance public health. Examples of such programs include public health education, wellness programs, and the sponsorship of educational activities.

- Serving Other Unmet Human Needs. Some tax-exempt hospitals provide important services that are tangential to health care but that are unmet by any other entity in the service area. Examples of these activities include senior citizen education and outreach programs, care for "boarder" babies, or the operation of a "meals-on-wheels" program.

We are concerned that the structure, content, and magnitude of information required by the revised form and schedules sets an expectation that compliance with tax-exempt regulations is *only* achieved if the dollar value of the community benefits provided equals the value of the tax-exemption. This expectation makes it difficult to acknowledge the intangible benefits related to the service and operation of tax-exempt healthcare institutions that are not readily measured in dollars. Importantly, such expectations obscure the fact that the IRS and court rulings have repeatedly determined that the promotion of health care is in itself a charitable activity.

We have found over the past 15 years that these 10 attributes have been a useful, comprehensive framework for articulating what makes an exempt organization different from its for-profit counterparts. Therefore, we urge the IRS to ensure that the form, schedules, instructions, as well as the field audit guides used to help interpret these materials, are structured to express these attributes, and that the form 990 and schedules allow healthcare providers to capture clearly all the relevant attributes by which they support the community benefit standard.

Reporting of Charity Care and Bad Debt

HFMA believes that currently, most healthcare organizations under-report charity care and over-report bad debt, largely because of the nature of healthcare delivery, and in many cases, the difficulty in obtaining appropriate financial information from patients to determine their financial status prior to service delivery. Historically, both charity care and bad debt were treated as uncompensated care and often were not clearly separated. As such, the difference between the two often was blurred.

To address this problem, in 2006, HFMA's Principles and Practices Board, updated Statement 15: *Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers.*

A noteworthy revision to Statement 15, which has important implications for charity care reporting as well as collection activities concerning unpaid patient bills, addresses how to record bad debt. The Principles and Practices Board states that revenue for patient services should be recognized only when it meets GAAP's revenue recognition criteria:

- Pervasive evidence exists of a payment agreement between the provider and the patient
- Services have been rendered
- The price is fixed or determinable, and
- Collectibility is reasonably assured

The accounting standard-setting bodies have clearly stated charity care results from an entity's decision to forego revenue. Bad debts, on the other hand, result from the customer/patient's refusal to pay for services that have met the criteria for revenue recognition listed above. (The full statement can be downloaded at http://www.hfma.org/ppb15)

Statement 15 also addresses the appropriate reporting of Medicare payment shortfalls:

> Medicare shortfalls, if disclosed, should be treated separately, because the program serves all elderly and disabled beneficiaries, regardless of income. This difference has resulted in a wide diversity of practice regarding the inclusion of Medicare shortfalls as community benefit. The Principles and Practices Board acknowledges that Medicare shortfalls can be an important issue for many providers, and that such losses can be material to the facility's financial status. The Principles and Practices Board concludes that each hospital should decide, based on its circumstances, whether Medicare shortfalls should be part of its community benefit disclosure. In all cases where Medicare shortfalls are disclosed, the disclosure should be separate from charity care and accompanied by sufficient detail and context to help readers understand each reported cost calculation. (Paragraph 11.2).

We recommend that the IRS incorporate Statement 15 guidance into its instructions for measuring and reporting charity care and bad debt. Also, in Schedule H, Line 3, we recommend adding a specific line item for Medicare payment shortfalls.

Billing and Collection Practices

Billing and collections practices is an important issue with significant policy implications. However, the information requested in Schedule H Part II does not provide evidence of how a facility complies with current regulations governing tax-exempt organizations. Therefore, HFMA recommends that this section be removed, or that the IRS explain how each set of information requested serves to demonstrate a provider's exempt-organization compliance.

Deadline

Finally, HFMA is deeply concerned about the proposed implementation deadlines, and we urge an extension to the filing deadline for the revised form and new schedules to tax year 2010. The extra time will allow affected entities to develop the additional processes which will be necessary to gather and prepare the additional information required in the new forms, especially draft Schedule K (Supplemental Information on Tax-Exempt Bonds). Also, the revisions the IRS makes to the form, instructions, and schedules after reviewing public comments are likely to be extensive. The extent of these changes, combined with the complexity of the information that the IRS seeks to capture, makes an additional review period prudent. To meet the tax year 2010 deadline, we hope to see the second draft early in 2008, with a final form released no later than December 31, 2008.

HFMA hopes that these comments and recommendations are useful as the IRS pursues the best interests of patients, taxpayers, and the nation's healthcare system. We are at your service to provide additional background material or perspective on this complex issue. You may reach me, or Richard Gundling, Vice President of HFMA's Washington, DC, office, at (202) 296-2920. We look forward to working with you.

Sincerely,

Richard L. Clarke, DHA, FHFMA

About HFMA

HFMA is the nation's leading membership organization for more than 34,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve health care by identifying and bridging gaps in knowledge, best practices, and standards.

From: Stroupe, Paulette L.

To: *TE/GE-EO-F990-Revision;

CC: Addiscott, Lynn;

Subject: Comments from Adventist Health System

Date: Friday, September 14, 2007 11:28:38 AM

Attachments: form990 file redesigned comments.pdf
image001.gif

Paulette L. Stroupe

Assistant to Lynn Addiscott, Senior Tax Officer &
Rob Roy, Senior Investment Officer
Adventist Health System
111 N. Orlando Avenue
Winter Park, FL 32789
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Adventist
HEALTH SYSTEM

September 14, 2007

Internal Revenue Service
Form 990 Redesign
ATTN: SE: T: EO
111 Constitution Avenue, N.W.
Washington, D.C. 20224

Dear Sir or Madam:

Adventist Health System Sunbelt Healthcare Corporation (AHSSHC) is the tax-exempt parent organization to a system of tax-exempt hospital, nursing home, and other healthcare provider subsidiary organizations. The system is known as Adventist Health System (AHS). In conjunction with its role as parent organization to the system, AHSSHC has set forth below its comments and/or questions with respect to the newly redesigned Form 990 that was released by the Internal Revenue Service (IRS) on June 14, 2007. The comments below are submitted on behalf of AHSSHC and all of its tax-exempt subsidiary organizations. Please note that a draft Form 990 comment letter was previously submitted by the AHS system in August of 2007. Accordingly, this correspondence is a follow-up to our earlier submission.

We understand that the IRS has redesigned the Form 990 based on three guiding principles, namely enhancing transparency, promoting tax compliance, and minimizing the burden on the filing organization. For each discussion item noted below, we have commented, as applicable, with respect to our view of how that item assists in achieving one or more of the above-stated IRS goals. We have also set forth in our comments below several recommendations for the revision/deletion of certain Form 990 information requests.

AHS would appreciate the opportunity to be a part of a face-to-face meeting with the IRS team who is responsible for the Form 990 re-design to offer our insight and share our perspectives on the proposed content of the Form 990 as it relates to hospital systems. With a deeper understanding of the IRS' objectives and goals with respect to the re-design of the Form 990, we believe that AHS could offer the IRS practical information concerning hospital industry data, including the accessibility of data and relevance to your stated goals.

Our comments below are grouped by topic/issue rather than by order of appearance within the new draft Form 990. Each discussion item below is preceded by the identity of its location within the draft Form 990.

COMPENSATION REPORTING:

- Schedule J, Page 1, Line 1, Column (C) – The draft instructions for this column indicate that all deferrals of compensation should be reported in this column, including earnings accrued on deferred amounts and/or increases (but not decreases) in actuarial value, if any.

  We do not understand why the total amount to be reported in column (C) would be required to include earnings accrued on deferred amounts and/or increases in actuarial values. Generally, once a deferred amount of compensation has been credited to a listed person, the individual determines investment decisions concerning the amount and particular investment fund in which he or she wishes to invest. Accordingly, the earnings accrued on deferred amounts would vary depending upon the individual's investment choices and on investment market conditions, and would not reflect the true amount that the tax-exempt organization provided as deferred compensation. Similarly, changes in actuarial values are not reflective of the actual amount of deferred compensation provided by the organization to the listed person and may vary depending upon a myriad of factors. Many of these factors are outside the control of the exempt organization.

  In our view, the inclusion of earnings and increases in actuarial value with respect to deferred compensation may provide a misleading picture of deferred compensation actually earned or credited to the listed person. Also we believe that inclusion of these items makes comparisons between organizations and within one organization over time less transparent because actual compensation is clouded by investment performance. It would also seem that if increases in actuarial value were to be disclosed, that decreases in actuarial value should also be disclosed in order to provide a complete picture of actuarial changes.

  Additionally, annual information concerning earnings and increases in actuarial value with respect to an individual's deferred compensation account is not typically readily available to the tax-exempt organization that is the sponsor of the deferred compensation plan. Gathering this data would often involve securing the information from a third-party vendor who handles all administrative matters concerning the investment of funds on behalf of employees.

  In summary, we believe the inclusion of earnings and/or increases in actuarial value on a deferred compensation amount allocable or set aside for a listed person is administratively burdensome, and detracts from the public's ability to compare deferred compensation amounts provided by tax-exempt organizations to their directors, trustees, key employees, and highly compensated employees due to the impact of market and other risk factors.

- Schedule J, Page 1, Line 1, Column (D) – This column asks for the reporting of all nontaxable fringe benefits provided to the listed person, including fringe benefits

excludable under IRC Section 132. The most common form of fringe benefits excludable under IRC Section 132 includes de minimis fringe benefits, qualified employee discounts, and working condition fringe benefits. Treasury Regulation §1.132-6(e) provides examples of benefits excludable as de minimis fringe benefits. These examples include, among others, such items as occasional personal use of an employer's copy machine, group meals or picnics for employees and their guests, coffee, doughnuts, and soft drinks, local telephone calls and flowers or similar property provided to employees under special circumstances (on account of illness, outstanding performance, or family crisis).

Column (D) of Schedule J appears to be asking the exempt organization to both value and track the total de minimis fringe benefits (and other fringe benefit categories set forth in IRC § 132) provided to an individual who is listed in Schedule J. In our view, the exclusion provided for de minimis fringe benefits was provided in order that employers need not track and report as compensation those items provided to employees (or other categories of workers as stipulated in the Regulations) that are so small as to make accounting for them unreasonable or administratively impracticable. We do not understand why exempt organizations should be treated differently and asked to track such small items for certain listed individuals. This would be an extremely burdensome requirement. Similar reasoning would apply to the other excludable categories of §132 fringe benefits.

In lieu of requiring the exempt organization to value and report all nontaxable fringe benefits, we suggest that a new question be added to Schedule J to inquire as to whether any of the listed persons received nontaxable fringe benefits that were not commensurate with those provided to rank-and-file employees. If the answer to that question were positive, the exempt organization should be required to provide an explanation of those differences.

- Schedule J, Page I, Line 1, Column (E) – This column requires that the total amount of nontaxable expense reimbursements be reported for each listed person. Similar to our comments above with respect to column (D), we believe it is administratively burdensome for an exempt organization to be required to compile and report each listed person's nontaxable expense reimbursements on an annual basis. Additionally, we are not sure how useful this information will be with respect to transparency and comparability. Certain listed individuals may incur significant amounts of business travel while others may not. The appropriate reimbursement of such business-related expenses incurred by listed persons under an accountable plan does not, in our view, provide further detail with respect to a listed person's total compensation as higher amounts of nontaxable expense reimbursements may be necessary for those individuals who travel significantly as a part of their job duties. System executive employees at a hospital system, such as AHS, often travel a good deal in connection with their duties in providing leadership to all of the subsidiary organizations within the system and, accordingly, may incur larger amounts of business travel reimbursements than an executive at a tax-exempt organization that operated one hospital at one campus site. As an example, AHS operates

in ten different states and so system-level executives are often required to travel in connection with fulfilling their job duties.

Rather than being required to report total nontaxable expense reimbursements provided to all listed persons, we recommend that the IRS consider deleting column (D) and inserting new questions into Schedule J that inquire about whether or not the organization reimburses business-related expenses under an accountable plan and whether or not the organization performs some internal audit function with respect to an annual review of selected executives' expense reports.

- Page 2, Part II, Section A, Line 1a – This section asks for compensation information with respect to officers, directors, trustees, key employees, and highly compensated employees and independent contractors. More specifically, the requested compensation information must be provided for all *former* officers, key employees, or highest compensated employees who receive more than $100,000 of reportable compensation from the organization and any related organization.

  We ask that the IRS reconsider the inclusion in this section of *former* highest compensated employees who received more than $100,000 of reportable compensation from the organization in the reporting year unless such persons would be considered disqualified persons under the intermediate sanctions provisions. In the case of *former* highest compensated employees who are not considered disqualified persons, we do not understand why the disclosure of current year compensation for such persons would be necessary. We are not aware of any statutory authority that would require a disclosure of such information. Compliance with this category of employees would require a separate tracking of the top five highest paid employees for each of the years in the five-year look-back period, adding to the administrative burden of completing Section A.

- Page 1, Part I, Line 7 – This line item asks for the highest compensation amount reported on Part II, Section A. We understand that Part I of the draft Form 990 is intended to provide a summary of other information detailed in the return. We wish to express our concern that with respect to question #7, the amount of compensation required to be reported may highlight one number out of context. For example, a key employee may receive a distribution from a non-qualified deferred compensation plan in any given year that would be reported in Box 5 of Form W-2. The inclusion of the deferred compensation distribution could result in a total compensation amount that, if reported separately on page one of Form 990 without the benefit of additional explanation, could be misinterpreted or misunderstood. We recommend that this line item be removed from Section 1 of Part I.

- Page I, Part I, Line 8a & b – These two items will provide a percentage of the organization's total program services expense that is represented by officer, director, trustee, and other key employee compensation. As in our remarks above concerning item #7 in this Part I, we believe that differences among organizations will provide a wide range of percentages in response to this question. The AHS system, not unlike other

hospital systems, employs all system-wide executives (CEOs, CFOs, etc.) and reports such executives' compensation on its payroll. Accordingly, its percentage of compensation for officers, directors and key employees compared to its total program services expense is likely to be higher than the percentage reported by one of its subsidiary hospital organizations. The potential wide range of responses to this question depending upon an organization's structure and operations will not provide sound or meaningful comparisons with respect to compensation practices among tax-exempt organizations. We recommend that this question be removed from Section I of Part I.

- Schedule J, Lines 4 & 5 – These two lines ask whether or not the organization paid or accrued any compensation to the persons listed above that was determined in whole, or in part, by the revenues or net earnings of the organization or any related organization. We request that the IRS provide a clarification to these two line items as to whether or not compensation arrangements that would be considered fixed payments as defined in IRC §4958 would be intended to not give rise to a positive response to these two questions.

GOVERNANCE, MANAGEMENT, & FINANCIAL REPORTING:

This Part III of the draft Form 990 appears to primarily seek information about policies, procedures, and practices of the reporting organization that are not statutorily required, but are representative of "best practices". We suggest that the information requested in this Part III be segregated into two different sub-headings, namely one sub-heading for "Statutory Requirements" and a second for "Best Practices". This segregation will assist a reviewer of the Form 990 to distinguish between those policies and procedures that are required under the law versus those that represent best practices.

- Page 4, Part III, Line 3b – This item asks for the number of transactions that the organization reviewed under its written conflict of interest policy and related procedures during the year. An annual determination of this number would require additional tracking and monitoring that would, in our view, not produce a meaningful number as a result of the tracking. We believe that the meaning of the word "reviewed" in this question could be interpreted differently by organizations unless further clarification is provided by the IRS. It would also appear that the number of transactions reviewed under an organization's conflict of interest policy may vary significantly depending upon the particular operations and activities of the reporting organization. The wide range of potential responses to this question will not, in our opinion, provide any meaningful information to a reviewer of the Form 990.

- Page 4, Part III, Lines 4 & 5 – These two lines inquire about whether or not the organization has a written whistleblower policy and/or a written document retention and destruction policy. While the existence of these two types of policies constitutes good management/governance practices, the existence of written policies is not required for income tax exemption under IRC §501(c)(3). It is our view that information that is of interest to the IRS with respect to data-gathering be compiled through a means other than

the annual Form 990. The Form 990 should generally be restricted to seeking information that relates to current IRS standards concerning exemption.

- Page 4, Part III, Line 11 – This question asks whether or not, and by what method, the organization makes available to the public its governing documents, conflict of interest policy, Form 990, Form 990-T, financial statements and audit report. As noted above with respect to lines 4 and 5, the information requested in this question appears to be related to IRS data-gathering with respect to all of the listed items except for the Form 990 and Form 990-T which are currently required to be made available to the general public. It is our view that the information requested in the question (other than with respect to the Form 990 and 990-T) should be solicited by the IRS through questionnaires and other correspondence. We are of the opinion that this question should be revised to include only the Form 990 and Form 990-T availability.

SCHEDULE K – SUPPLEMENTAL INFORMATION ON TAX EXEMPT BONDS

- Schedule K, Page 1, Part I - This schedule appears to have been developed from the perspective of a stand-alone entity with a series of single purpose bond issues. We believe that we have a robust post issuance compliance process in place and are continuing to enhance it each year. Even with the system we have in place we see a huge administrative burden in complying with this schedule. AHS would love to see some examples of how you would treat our situation. Any given bond issue at our organization can be allocated to one, all, or somewhere in between of our 35 hospitals and 17 nursing homes. At any location there can be multiple projects and hundreds of equipment purchases that are financed with the bond proceeds. The request to provide even summarized detail and corresponding placed in service information is going to be a significant undertaking for each bond issue. Extrapolate this to approximately 100 outstanding bond issues and defiance escrows and you start to get a picture of what kind of burden we are looking at. When you couple this schedule with the significant compliance burden of the other parts of the revised Form 990, we believe that at a minimum this Schedule should be implemented at least two years following the adoption of the new revised Form 990.

- Schedule K, Page 2, Part III - Line 4 indicates that if an affirmative answer is given to Lines 2a and 3a related to management contracts and research agreements, then the highest percentage of the project subject to the agreements is to be reported. In our opinion this question should be deleted since it is asking for a report on use that meets safe harbors established by the IRS. In our system, we have hundreds if not thousands of contracts that meet the specified safe harbors and it would be administratively burdensome as well as absolutely irrelevant to summarize the use of space under these contracts.

- Schedule K, Page 2, Part III, Line 5 - Similar to the comment above, the requested reporting of the use of facilities may not qualify as private use based on regulatory

exceptions. We would suggest limiting the disclosure to uses that result in private use to limit the administrative burden on taxpayers.

SCHEDULE H – HOSPITAL:

- Schedule H, Page 1, Part I, Community Benefit Report – As noted in our prior submission of comments to the IRS with respect to the redesigned Form 990, we are of the opinion that the unreimbursed costs of providing medical care to the elderly community that are covered by the Medicare program should be considered part of the benefit provided to the community by tax-exempt hospitals. Tax-exempt hospitals are required to participate in the Medicare and Medicaid programs and so must accept Medicare and Medicaid reimbursement rates for the services they provide to patients who are covered beneficiaries of these programs. Serving these patients is a part of the benefit that tax-exempt hospitals provide to their communities and should be reported as a component of community benefit. We refer you to our previous submission of preliminary comments, dated August 8, 2007, for an expanded discussion of this issue.

- Schedule H, Page 1, Part I, Line 7, Other Community Benefits – This line item asks for certain information for subsidized health services. The instructions for Schedule H, Part I, line 7 define subsidized health services as clinical services provided despite a financial loss, when the financial loss is so significant that negative margins remain after removing the amounts of charity care and Medicaid shortfalls. We are of the opinion that this item, as currently defined, is open to varying interpretations. We believe that the intent of this line item is to capture information concerning an organization's unreimbursed costs of providing certain clearly identifiable community health programs, such as urgent-care clinics, specialty care clinics located in low-income neighborhoods, burn units located within a hospital, and organ transplant programs operated by a hospital. Our recommendation is that the IRS clarify the definition of subsidized health services to capture what we believe is their intent of what should be reported on this line and to provide examples of the type of programs/services that should be reported.

- Schedule H, Page 1, Part I – For each community benefit line item in this section under the heading of "Charity Care" or "Other Benefits", column (a) asks for the number of activities or programs conducted. It is our opinion that determining the annual number of activities or programs conducted for any of the community benefit items listed in the rows of Part I will be very subjective and subject to varying interpretations. For example, in determining the number of activities or programs conducted in connection with research, a hospital could consider its total research program at any particular hospital site as one activity. Alternatively, it may treat research conducted for various disease conditions to be separate activities even though all the research is performed at a single hospital campus. For example, cardiac research may be treated as one activity and diabetes research may be considered a separate activity. Alternatively, a hospital could determine that each separate research project (clinical trial) should be considered a separate activity. Accordingly, there could be widely disparate answers to this item. We do not believe that the number of activities has any relevant bearing on the other data

collected. We do not see the correlation between the number and the amount of benefit provided. It is our recommendation that the IRS remove column (a) from Part I of Schedule H.

- Schedule H, Page 2, Part V – This section requires the organization to provide the name and address of each of the organization's facilities. In addition, for each facility, the type of service provided at the facility and a description of the activities and programs conducted at the facility must be set forth. We recommend that the IRS revise its definition of "facility" for purposes of this section of Schedule H to only require a separate listing of individual hospital campus sites, along with a reporting of the total number of other outpatient facilities by type (i.e. outpatient surgery centers, physician practice clinic sites, imaging centers). A requirement to list out any and all sites where hospital or medical care is provided will be burdensome in terms of gathering and reporting this information each year. As an example, a large hospital operating several campuses may also own and operate a number of clinic sites, imaging sites, and outpatient physician practice sites. The time anticipated to be involved in gathering this data and reporting it does not appear to be warranted in terms of providing the public with additional information about the scope of a hospital organization's activities. As an example, it would seem that the public would be just as well informed about the organization's general activities/programs to know that Hospital X operates three outpatient imaging centers, twenty physician practice sites, and two outpatient surgery centers as it would if all 25 of these facilities were listed individually.

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We appreciate being given the opportunity to submit these comments to you. Thank you for consideration of the recommended changes that are set forth in the narrative above.

Very truly yours,

Terry D. Shaw
Chief Financial Officer

Lynn C. Addiscott
Senior Tax Officer

ADVENTIST
HEALTH SYSTEM

August 8, 2007

Mr. Ronald Schultz
Senior Technical Advisor for Tax-Exempt and Government Entities
Internal Revenue Service
111 Constitution Avenue, N.W.
Washington, D. C. 20224

Dear Mr. Schultz:

On behalf of Adventist Health System, I am providing our preliminary comments to the proposed changes to IRS Form 990. Our major areas of concern have to do with the inclusion of Medicare shortfalls, capital investments that serve the community, and cash reserves.

During a conference call on June 28, IRS staff said it was not IRS's intent to change the current community benefit standard for tax-exempt hospitals, but rather to better quantify that standard. We applaud that effort. We also firmly believe that any revisions to the 990 should reflect those elements consistent with IRS Rulings 56-185 and 69-545, and expanded upon in IRS Ruling 83-157. These are the major historic revenue rulings on tax-exempt hospitals that have guided community benefit reporting for almost 40 years.

Our first concern with the revised form is the exclusion of Medicare shortfalls as community benefit. Ruling 69-545 expressly requires hospitals to participate in the Medicare and Medicaid programs as a condition of tax-exemption. As a result, shortfalls in these programs remain an integral part of the community benefit standard. Ruling 83-157 says, "Other significant factors, however, including....treatment of persons paying their bills with the aid of public programs like **Medicaid and Medicare...** indicate that the hospital is operating exclusively to the benefit of the community." It is absolutely consistent with both IRS rulings that tax-exempt hospitals report shortfalls in Medicare when quantifying community benefit. Conversely, excluding Medicare shortfalls is not consistent with either ruling, and effectively removes the expectation that tax-exempt not-for-profits participate in Medicare.

We believe you may have relied in part on the Catholic Health Association's recommendations on Medicare shortfalls. CHA takes a limited view of community benefit owing to their unique religious mission. As a faith-based

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health system ourselves, Adventist Health System does not believe that one view of mission should be imposed upon a whole industry, especially when that view is inconsistent with established IRS policy. The American Hospital Association also favors the inclusion of Medicare shortfalls in community benefit reporting.

Revenue Ruling 83-157 defines the indicators for hospitals operating exclusively for the benefit of the community (as opposed to for-profit entities that operate for the benefit of the owners or shareholders). These indicators include an open medical staff policy and, as discussed, Medicaid and Medicare shortfalls (69-545 and 83-157). Other indicators include executive compensation (56-185), charity and discounted care to the uninsured (56-185, 69-545 and 83-157), and the application of surplus cash to expenditures for facilities, equipment, patient care, medical training, education and research (56-185and 83-157).

Specifically, Ruling 83-157 says not-for-profit, tax-exempt hospitals should apply "any surplus to improving facilities." We agree. Within prudent business operating principles, not-for-profit hospitals should expend their surpluses for facilities, equipment, programs, etc., over time and for the benefit of the community. We suggest that hospitals report their spending on facilities, equipment and programs in multi-year totals in order to truly reflect planning and capital investment cycles. A five-year rolling aggregated number would be appropriate.

The issue of cash reserves is our final concern. Tax-exempt hospitals should not retain excess cash beyond that required for sound ratings in the tax-exempt finance market. We suggest that hospitals report their cash-on-hand to the IRS, and that cash-on-hand be limited to 275-300 days in reserves. Extra reserves could be subject to a surtax if not spent within a year for capital or program enhancements. The reporting of cash-on-hand and capital spending would allow for clear financial accountability for institutions that should be operating for the benefit of their communities.

Adventist Health System will also have some technical comments to make on some of the schedules and calculations. We will forward those in separate correspondence.

Thank you in advance for your attention to our recommendations. If you would like to discuss our comments, please do not hesitate to call me at 407-303-1607.

Sincerely,

Richard E. Morrison
Corporate Vice President